U.S. Department of State
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

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EXPIRATION DATE: 06-30-2017
ESTIMATED BURDEN: 1 HOUR

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE

FOR INDIVIDUALS AGE 12 AND OLDER

PRIVACY ACT NOTICE

AUTHORITIES: The information is sought pursuant to the Foreign Service Act of 1980, as amended (22 U.S.C. §§ 4084, 3901, 3984).

PURPOSE: The information solicited on this form will be used to make appropriate medical clearance decisions.

ROUTINE USES: The information on this form maybe shared with personnel in the Office of Medical Services. Unless otherwise protected by medical privacy regulations, the information may be made available to appropriate agencies, whether Federal, state, local or foreign, for law enforcement and administration purposes. It may also be disclosed pursuant to court order. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records.

DISCLOSURE: Providing this information is voluntary. However, failure to provide the information requested on this form may result in denial of a medical clearance. Also, if you are an applicant to the Foreign Service, your failure to provide the information requested on this form may affect your Foreign Service eligibility.

PAPERWORK REDUCTION ACT STATEMENT: Public reporting burden for this collection of information is estimated to average one (1) hour per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: M/MED/EX, Room L217 SA-1, U.S. Department of State, Washington, DC 20522

I. To Be Filled Out By Examinee *(Complete all sections, type or in ink.)*

1. Name of Examinee *(Last, First, MI.)*

Date *(mm-dd-yyyy)*

2. Full Name of Employee/Applicant/Sponsor

3. eMED Number if known *(Employee/Applicant/Sponsor)*

4. Date of Birth *(mm-dd-yyyy)*

5. Sex ☐ Male ☐ Female

6. Place of Birth

City _____ State _____ Country _____

7. Status

☐ Applicant/Employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other

8. Name of your Health Insurance Plan

9. Purpose of Exam

☐ Separation ☐ In Service ☐ Pre-Employment

10. Agency of Employee/Applicant/Sponsor

☐ State ☐ USAID ☐ Foreign Commercial Service ☐ Foreign Agricultural Service ☐ Board of Broadcasting Governors

11. Your Mailing Address *(Medical Clearance Abstract will be mailed to listed address.)*

_____

_____

_____

Telephone Number (where you can be reached for the next 90 days) _____

E-mail (where you can be reached for the next 90 days) _____

_____

12. Post of Assignment and Dates of Departure/Arrival

a. Proposed Post _____

EDA _____ *(mm-dd-yyyy)*

b. Present Post _____

ED _____ *(mm-dd-yyyy)*

c. Last 3 Posts _____

_____

_____

To the Doctor: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.